SHEM'S STORY

It was a warm Friday evening in September, 1994. The phone rang; the news was dire. My beloved nephew, Shem, lay dying in the county hospital. If I wanted to see him alive, I needed to get down there right away; he was in the Urology Ward, after being hospitalized on Labor Day.

As I raced to the hospital, a thousand thoughts raced through my head: "Urology Ward? How is that possible? What could be threatening his life on the *Urology Ward*? What could have happened? He was well just a week ago. How am I going to get in to see him? It's after visiting hours. Why didn't they call me sooner?" Of course, I knew the answer to the last question. Just a month earlier, my sister and I had had a major blowout. All of my family are dedicated members of a close-knit religious community. I had left the faith some years before, and an issue arose which deeply offended my sister's religious conscience. She disowned me completely, and even had forced my nephew to write me a letter doing the same. Since Shem and I were extremely close – he had even lived with me for a few months when he needed a refuge from family problems, it was devastating when I received his letter just a week or so before he became ill. I felt guilty that the rift between us had resulted in Shem's becoming so seriously ill; that I had not been there for him as a resource. And, running through and under all the surface worries and concerns was the thought: "What will I be able to do for him?" I couldn't imagine not fighting for his life. Yet, did I have the tools to succeed?

When I arrived at my nephew's bedside, I was appalled by his condition. Although fully conscious, he was paralyzed and terrified. Most significantly, he was exhibiting Cheyne-Stoke breathing, indicating severe neurologic damage. The day before, the hospital had tried to discharge him. It took a male orderly and his father to get him back into bed after the nurse had forced him into a wheelchair. The nurse had obviously thought he was being melodramatic, because her admonition at the time had been, "Come on. Be a man."

I performed a cursory examination. His official diagnosis was prostatitis. My mind was screaming, "Prostatitis!! How can the doctors be so blind?!? This isn't prostatitis." Upon exam, his prostate was enlarged and boggy, although it was non-tender. I later learned that his symptom pattern had begun with an inability to urinate, so at the infirmary, they had done a perfunctory history and assigned him to the Urology Ward. However, the urology symptoms were only the tip of the ice berg. In addition to an inability to urinate, he had severe head and neck pain, and had developed advancing flaccid paralysis. By the time I saw him, the condition had advanced to fasciculations in the temporalis muscle. The twitches signaled death of motor neurons in his brain stem. His grip strength was almost non-existent, and he couldn't move – he couldn't roll over, he couldn't move his arms or legs, about all he could manage was to lift his little finger. I took his hand and told him to squeeze with all his might. I could barely feel any pressure on my hand.

By now, I was pretty clear about what was wrong. There are only a few conditions that affect only motor nerves, leaving the sensory nerves and consciousness intact: he had bulbar poliomyelitis. I was fully aware of the medical prognosis for lower motor neuron disease. The medical goal is to limit the damage, because any neurons that are damaged never recover. There is no question of whether or not the patient will be disabled; it's only a question of how severe the disability will be. Shem's outlook was pretty grim, since he was exhibiting signs of damage to the nerves that control respiratory function. In the 50's these people ended up in an iron lung; nowadays, we put them on respirators with permanent tracheotomy tubes.

In my head I heard my mentor's voice echoing: "Move the cerebrospinal fluid. If you do, you can reverse the paralysis." I had never seen a case of polio, and my mentor had been dead for more than 5 years. But, his words were all I had to go on. He had taught me Neurovascular Dynamics (NVD), a specific system of reflex areas that open the circulation and move the bodily fluids. There were specific points on the cranial vault which would move the cerebrospinal fluid. So, the first thing I did was treat Shem, using NVD, as he lay in his hospital bed. His condition changed only minutely: There was about a 5% - 10% improvement in his grip strength. But, it told me I was on the right track.

At this point, I faced some difficult, yet necessary, actions. My brother-in-law and sister were beside themselves. They knew something was seriously wrong, but no one had told them what. Someone had to break the news. Also, I needed to get the hospital staff on the job. When I mentioned to the ward nurse that his temporalis

muscle was fasciculating, she looked at me blankly. Clearly, the penny had not dropped and no one was making any effort to diagnose his condition, much less treat it. Leaving Shem lying there was the surest way to destroy his life.

I went out to the duty station, where I encountered the young man on night duty. He must have been a medical student, but he looked about 16 to me. I informed him of my working diagnosis – bulbar poliomyelitis. His eyes got as big as saucers, and his response was, "I've never seen a case." I advised him that he had better get ready to intubate my nephew, since he was losing the ability to breathe. At that point, things began to happen. He immediately got on the phone and arranged for someone to come and do a lumbar puncture. Also, he called for help, since he was now clear he had a serious neurologic problem on his hands. This was around 10 pm; by midnight they had completed the lumbar puncture; and around 2 am they transferred my nephew to the Intensive Care Unit on the Neurology Service.

Next, I went back to my family and took them into a private space, away from my nephew. I needed to tell them the truth. My brother-in-law had contracted polio as a teenager and survived; however, he has one leg that is partially paralyzed. And, it left him with a horror of the disease. They were stunned by the implications of what I told them. Fortunately, I was able to add that there was a great deal I could accomplish as long as I had access to Shem. I told them that Dr. Martin had routinely treated polio and that it was possible, but by no means certain, that he could recover.

Of course, the real problem was access. As a chiropractor, I was aware that hospitals would routinely deny me access to my patients once they had been admitted. Their excuse: I would need staff privileges in order to offer treatment. However, obtaining staff privileges is a lengthy and costly process – taking six months to a year. And, how many hospitals can you apply to, on the off chance that one of your patients may need you? And, in fact, it was exactly as I feared, the hospital did everything possible to keep me away from Shem.

When I got back to the hospital on Saturday morning, after a few hours sleep, Shem was asking for me. In spite of the multitude of medications they had prescribed, it seemed that I was the only one who could relieve his head pain. The NVD contacts on the back of his skull, over the damaged areas, brought him a great deal of relief. Interestingly, I could feel the vasomotor activity under my fingertips and could tell whether his condition was improving or worsening before the lab tests returned.

At first, the hospital staff seemed glad that there was a doctor available who knew Shem's entire medical history. However, when they discovered I was a doctor of chiropractic, the discounted everything I told them, and tried to make it impossible for me to enter ICU, but my sister was like a tiger with a single cub. After the second or third time one of the staff came and gave them a rundown on Shem's condition, simply so they could end with the statement, "And keep ***her*** away from him," my sister stood toe-to-toe with the head resident and informed him, "You have almost killed my only remaining child. She's his doctor. She's been his doctor his entire life, and she ***will*** continue to treat him."

A single example of their obstructionism will suffice. My nephew suffers with celiac disease, a genetic inability to digest gluten. I informed them of his condition, but when they learned that I had made the diagnosis, they obviously ignored it. No special instructions were given to the kitchen to eliminate gluten from his diet. In fact, they put wheat flour in all of his food, including the orange juice! When the inevitable happened, explosive diarrhea, the nurses on staff were left to deal with the consequences. In his debilitated condition, the miracle is that the food didn't kill him.

They then attempted to influence my brother-in-law. I wasn't privy to the encounter; however, my brother-in-law called me at home in the morning (I believe it was Sunday), and suggested I should back off for fear that the hospital would kick Shem out. It was a pretty rough conversation. I was forced to confront him with the facts. Either I treated Shem or the medical prognosis would prevail. If he survived at all, it would mean a lifetime of disability – in a wheelchair and breathing through a respirator. The medical profession had no vision of recovery from this type of neurologic insult. I also told him that the hospital didn't dare discharge Shem; the potential liability was too great. After all, he had lain in their Urology Ward for a week, undiagnosed, as his condition progressed. And, I had no power in the situation. Either he and my sister maintained a united front, assuring me access, or Shem would suffer. I told him it was up to him.

When I got back to the hospital, the staff neurologist was conducting rounds. They had Shem's x-rays and MRI studies at his bedside. I became an unwelcome intruder. I simply refused to leave. I wanted a look at the films and lab studies. When I saw a lateral view of his brain and cervical spine, my heart sank. His neural tissue was white with the evidence of strokes halfway down the cervical spine. Since C3, C4 and C5 control the diaphragm, it was obvious why he was having trouble breathing. As I stood there, one young intern, who obviously considered herself a hotshot, tried to intimidate me. She spoke to me as though I were a mentally retarded child, "He's suffered multiple brain stem strokes." Her implication was clear: my feeble efforts would be useless. Unfortunately, she said that right in front of my nephew, as though he were an inanimate object. It was the first intimation he had had of the seriousness of his condition. He turned white as a sheet, and tears welled up in his eyes. I could see what he was thinking running through his mind. Then he said, "Strokes? But I'm only 20 years old!" His despair cut me to the heart, while I was enraged at the insensitivity of the intern who had just treated him like a non-person. The attending physician was kind, patting Shem's leg and attempting to reassure him, but it was obvious that he didn't know what to say, either, given what he "knew" about the prognosis.

Of course, all I had to work with were my two hands and my knowledge of NVD. In the face of all the monitors and equipment hooked up to Shem's body, I'm sure the medical staff considered my attempts to be farcical. But I ***knew*** what I was feeling under my hands and I ***knew*** how Shem's symptoms were changing. Every time I treated him (which was almost hourly initially), the vasomotor response would go from totally chaotic to organized. Each time, it was a little stronger; and, over time, Shem's motor paralysis was improving. Therefore, I had confidence that his body was responding, even though I was still very concerned about his ability to breathe.

Indeed, as I had predicted, his diaphragm became totally paralyzed, and he was intubated on Sunday morning. The hospital staff had told my sister and brother-in-law to go home. The promise was that they would call if there was any change. When my sister and I arrived at the hospital, they had a staff physician preparing to insert a tracheal tube without having contacted Shem's family. My sister went ballistic. Once again, she demanded that I have access (I needed to do a cranial adjustment to more strongly move the cerebrospinal fluid before they inserted their device). She also insisted that we speak to Shem before the procedure was done. Once the tube was inserted, he would be unable to speak, and my sister wanted to establish a system of signs that would allow Shem to ask for me, if he needed pain relief. The resident tried to force the issue by saying, "The doctor is available now. He needs to complete the procedure while he's on the ward." My sister was brilliant in her reply, "Well, the doctor can just *come back.*"

So, I got in there and did what was necessary. I'm quite sure the hospital staff believed I had killed Shem by spreading the infection when I did an intraoral cranial adjustment. However, the proof is in the outcome: Within 40 hours, Shem had weaned himself off of the respirator and was breathing on his own. The hospital staff was afraid to remove the breathing tube. They had never seen anyone recover from the amount of brain damage they could see on Shem's MRI and they could only worry that his breathing would fail again. Once again, we were treated to 3 or 4 staff members coming to report on my nephew's condition, each ending with "and keep her away from him."

The most interesting part of the entire scenario was that Shem had the entire hospital puzzled. The attending and the residents both told us that they were conducting daily staff conferences to try to figure out what was wrong. At one point, he was hooked up to nine different IV tubes, which included multiple antibiotics, an antiviral and cortisone. Since his illness did not fit any known condition (of course not, he was *regaining* function), they were hard-pressed to make a diagnosis. So, in their treatment plan, they were trying to cover all the bases. In the final analysis, they never did diagnose him. They simply described the process, without any attention to the cause. Also, I was told they were going to publish a paper on the remarkable course of his illness. I wish I had a copy. It must make entertaining reading, since none of them had a clue why he was getting better.

Once he came off the respirator, Shem's progress was dramatic. He spent 10 days in ICU until he was able to sit up and get around in a wheelchair. He was in the Neurology Ward for about 3 weeks until he was able to walk. During that time, I made multiple trips to the hospital each day to treat him, while maintaining my private practice. As his condition improved, I was able to decrease the frequency of treatment from several times a day to three times a day, to twice, to once.

I have in my files his MRIs, taken 2 weeks apart, showing demyelinization and remyelinization of his brain. Almost all trace of the lesions disappeared as his brain healed itself. My theory (unproven at this point) is that, given the opportunity, associative neurons will take over the function of the neurons that have died. Inducing the vasomotor response reduces the inflammation and allows the neural tissue to organize itself and respond by reinstating functional pathways to replace the loss.

After 4 weeks, Shem was discharged from the hospital and made a complete recovery. Looking at him, you would never know how serious his brain damage had been. And, were it not for the MRIs in my possession, there would be no evidence that he had ever had multiple strokes. If I didn't have a copy of the films, I think I would begin to doubt what NVD had accomplished.

This experience truly changed my perception of both myself and the healing professions. During the critical days, when it was uncertain whether Shem would even survive, I was the center to whom everyone turned. All hope for Shem's recovery rested with me, and I had to hold the space with positivity and encouragement. I, too, was terrified. After all, I had studied all the same books on medical diagnosis. I knew better than anyone else in the family what the prognosis was. All I had to go on was Dr. Martin's anecdotal instruction on how to treat polio. And, I gained a new appreciation of how much vital information we have allowed to slip away in chiropractic. It renewed my determination to teach and share NVD with others. Who knows when someone else will need to know?

In the process of the doing, I found out that I was stronger than I had believed possible. Also, I was gifted with the knowledge that our work is powerful and life-saving. No one and nothing can take that knowledge away from me. I have a new inner certainty and authority that I never had before.

It also provided me with a new appreciation for the medical support system of hospitals and nursing staff. It is an awesome and lonely responsibility to be "the only." After my nephew recovered, I felt even more alone. I clearly remember driving home from the hospital, finally sure that the crisis was over and he would recover fully, wanting to party and shout from the rooftops. But, there was no one to share the joy and elation. My family's faith in me had been unwavering. They never truly shared my horror of failure.

Finally, it illuminated for me what I consider to be a major threat to the health of the American public: The number of doctors who "know" you can't get better. After all, their textbooks and their training say so. The whole point of making a diagnosis is so that the doctor will "know" the course and prognosis of your condition. No where is this more true than in neurology, although it exists in other specialties, as well: cardiology and oncology, for example.

I believe that a major portion of the healing process is the exchange between the doctor's intent and the patient's response. If your doctor "knows" that you cannot get well, how can you fight that? After all, he or she is the expert. But we don't train doctors to be healers. We train them to be technicians. We have lost sight of the miracle that is our body's self-healing mechanism. Believe me, if your body were unable to heal itself, no surgeon would dare to make the first incision. Yet, in medical practice, the focus is on the razzle-dazzle of the machines and technology, rather than on the simple miracle that is the resilience of the human organism.

I hope that this attitude will change. As long as we train our doctors to believe that we know everything about a familiar condition, like polio, then we have closed the door of possibility. There is no room for another, perhaps better, model.

PATIENT: #590-74-59

REFERRING PHYSICIAN: DR. RIDGE (5800)

DATE OF EXAM: 9/10/94

EXAMINATION: MRI OF THE BRAIN

HISTORY:
21 year old male with a clinical history of meningitis. The patient presents now with signs suspicious for a brainstem injury. However, there is also loss of bowel and bladder function, and the possibility of a spinal cord lesion is also raised.

TECHNIQUE:
The following 3 sequences were performed:
Sag T1 686/15; Ax ME 2800/25-80; Ax T1 450/15.

FINDINGS:
The soft tissues of the scalp and bony calvarium are unremarkable in appearance. No extra-axial fluid collections are identified. No intra or extra-axial masses are seen. The ventricular system is normal in caliber without evidence of hydrocephalus. There is diffusely increased T2 signal throughout the pons bilaterally. This extends into the medulla inferiorly, mostly on the right. The pons does not appear to be expanded, and no abnormal contrast enhancement is seen in this area. No abnormal parenchymal or meningeal enhancement is present. No other focal parenchymal abnormalities are seen.

IMPRESSION:

1. DIFFUSELY ABNORMAL T2 SIGNAL WITHIN THE PONS, WITH SOME EXTENSION INTO THE MEDULLA, PREDOMINANTLY ON THE RIGHT. NO ASSOCIATED MASS EFFECT OR CONTRAST ENHANCEMENT IS SEEN. THE FINDINGS ARE NON-SPECIFIC, BUT THE MOST LIKELY DIFFERENTIAL CONSIDERATIONS WOULD BE ACUTE DEMYELINATING DISEASE, SUCH AS MULTIPLE SCLEROSIS, VERSUS ENCEPHALITIS VERSUS A DEGENERATIVE PROCESS SUCH AS WILSON'S DISEASE OR CENTRAL PONTINE MYELINOLYSIS VERSUS AN ISCHEMIC EVENT. THE ABSENCE OF MASS EFFECT OR CONTRAST ENHANCEMENT MAKES A NEOPLASM MUCH LESS LIKELY.

2. NO ABNORMAL PARENCHYMAL OR MENINGEAL ENHANCEMENT.

J. AHMADI, M.D. - Staff/ M. WOHLBERG, M.D.
JA:MW:hc
D: 9/13/94 T: 9/13/94

LAC IMAGING SCIENCE CENTER USC

UIA USC

PATIENT: #590-74-59

REFERRING PHYSICIAN: DR. KOM (5800)

DATE OF EXAM: 9/23/94

EXAMINATION: MRI OF THE BRAIN

HISTORY:

21 year old male with a history of meningeal encephalitis and celiac spur; now presents with the loss of bowel and bladder function.

TECHNIQUE:

The following 4 sequences were performed:
Sag T1 686/15; Ax ME 2800/25-80; (Brainstem) 2300/25-80; Ax T1 686/15.

FINDINGS:

Comparison is made to prior study of 9/10/94. The ventricles are of normal size and morphology. There is no evidence of an intra-axial or extra-axial cerebral mass. No subdural collection is present. No sellar mass is seen. The increased signal intensity that was seen in the pons and medulla on 9/10/94, has improved. The lesion is smaller and has high signal intensity with respect to the pons on T2 weighted images. The 4th ventricle is normal in caliber without any appreciable mass effect. Normal flow void signal is also seen in the basilar artery. The paranasal sinuses are clear.

IMPRESSION:

INTERVAL IMPROVEMENT IN THE PONTINE/MEDULLAR LESION. FOLLOW-UP STUDY IS RECOMMENDED.

P. COLLETTI, M.D. - Staff/ S. SAHU, M.D.
PC:SS:hc
D: 9/23/94
T: 9/26/94